



**Department of Veterans Affairs  
Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 14-00232-110**

**Community Based Outpatient Clinic  
and Primary Care Clinic Reviews  
at  
VA Loma Linda Healthcare System  
Loma Linda, California**

**March 31, 2014**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**

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## Glossary

AUD	alcohol use disorder
CBOC	community based outpatient clinic
DWHP	designated women's health provider
EHR	electronic health record
EOC	environment of care
FY	fiscal year
MH	mental health
MM	medication management
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NM	not met
OIG	Office of Inspector General
PACT	Patient Aligned Care Teams
PCC	primary care clinic
PCP	primary care provider
PII	personally identifiable information
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH	women's health

# Table of Contents

	Page
<b>Executive Summary</b> .....	i
<b>Objectives, Scope, and Methodology</b> .....	1
Objectives .....	1
Scope .....	1
Methodology .....	2
<b>Results and Recommendations</b> .....	3
EOC .....	3
AUD .....	5
MM .....	7
DWHP Proficiency .....	8
<b>Appendixes</b>	
A. CBOC Profiles and Services Provided .....	9
B. PACT Compass Metrics .....	11
C. VISN Director Comments .....	15
D. Facility Director Comments .....	16
E. OIG Contact and Staff Acknowledgments .....	20
F. Report Distribution .....	21
G. Endnotes .....	22

## Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected patient care activities to determine whether the community based outpatient clinics (CBOCs) and primary care clinics (PCCs) provide safe, consistent, and high-quality health care for our veterans. We conducted a site visit during the week of February 3, 2014, at the Rancho Cucamonga, CA, CBOC which is under the oversight of the VA Loma Linda Healthcare System and Veterans Integrated Service Network 22:

**Review Results:** We conducted four focused reviews and had no findings for the Designated Women's Health Providers' Proficiency review. However, we made recommendations in the following three review areas:

Environment of Care. Ensure that:

- Personally identifiable information is protected by securing laboratory specimens during transport from the Rancho Cucamonga CBOC to the parent facility.

Alcohol Use Disorder. Ensure that CBOC/PCC:

- Staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Staff provide education and counseling for patients with positive alcohol screen and drinking alcohol above National Institute on Alcohol Abuse and Alcoholism limits.
- Staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
- Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

Medication Management. Ensure that CBOC/PCC staff:

- Document that medication reconciliation was completed at each episode of care where medications were administered, prescribed, or modified.
- Provide medication counseling/education that includes the fluoroquinolone.

## Comments

The VISN and Facility Directors agreed with the CBOC review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15-19, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## **Objectives, Scope, and Methodology**

### **Objectives**

The CBOC and PCC reviews are an element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care services. As such, the CBOC and PCC reviews are recurring evaluations of selected primary care operations that focus on patient care quality and the EOC. In general, our objectives are to:

- Determine whether the CBOCs are compliant with EOC requirements.
- Determine whether CBOCs/PCCs are compliant with VHA requirements in the care of patients with AUD.
- Determine compliance with requirements for the clinical oversight and patient education of fluoroquinolones for outpatients.
- Evaluate if processes are in place for DWHPs to maintain proficiency in WH.

### **Scope**

To evaluate for compliance with requirements related to patient care quality and the EOC, we conducted an onsite inspection, reviewed clinical and administrative records, and discussed processes and validated findings with managers and employees. The review covered the following four activities:

- EOC
- AUD
- MM
- DWHP Proficiency

The scope of this review is limited to the established objectives. Issues and concerns that come to our attention that are outside the scope of this standardized inspection will be reviewed and referred accordingly.

## Methodology

The onsite EOC inspection was only conducted at a randomly selected CBOC that had not been previously inspected.<sup>a</sup> Details of the targeted study populations for the AUD, MM, and DWHP Proficiency focused reviews are noted in Table 1.

**Table 1. CBOC/PCC Focused Reviews and Study Populations**

<b>Review Topic</b>	<b>Study Population</b>
AUD	All CBOC and PCC patients screened within the study period of July 1, 2012, through June 30, 2013, and who had a positive AUDIT-C score <sup>b</sup> and all providers and RN Care Managers assigned to PACT prior to October 1, 2012.
MM	All outpatients with an original prescription ordered for one of the three selected fluoroquinolones from July 1, 2012, through June 30, 2013.
DWHP Proficiencies	All WH PCPs designated as DWHPs as of October 1, 2012, and who remained as DWHPs until September 30, 2013.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

The review was done in accordance with OIG standard operating procedures for CBOC and PCC reviews.

<sup>a</sup> Includes 93 CBOCs in operation before March 31, 2013.

<sup>b</sup> The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders. Scores range from 0–12.

## Results and Recommendations

### EOC

The purpose of this review was to evaluate whether CBOC managers have established and maintained a safe and clean EOC as required.<sup>1</sup>

We reviewed relevant documents and conducted a physical inspection of the Rancho Cucamonga CBOC. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

**Table 2. EOC**

NM	Areas Reviewed	Findings
	The CBOC's location is clearly identifiable from the street as a VA CBOC.	
	The CBOC has interior signage available that clearly identifies the route to and location of the clinic entrance.	
	The CBOC is Americans with Disabilities Act accessible.	
	The furnishings are clean and in good repair.	
	The CBOC is clean.	
	The CBOC maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates.	
	An alarm system and/or panic buttons are installed and tested in high-risk areas (e.g., MH clinic).	
	Alcohol hand wash or soap dispenser and sink are available in the examination rooms.	
	Sharps containers are secured.	
	Safety needle devices are available.	
	The CBOC has a separate storage room for storing medical (infectious) waste.	
	The CBOC conducts fire drills at least every 12 months.)	
	Means of egress from the building are unobstructed.	
	Access to fire alarm pull stations is unobstructed.	
	Access to fire extinguishers is unobstructed.	
	The CBOC has signs identifying the locations of fire extinguishers.	
	Exit signs are visible from any direction.	
	No expired medications were noted during the onsite visit.	
	All medications are secured from unauthorized access.	

NM	Areas Reviewed (continued)	Findings
X	PII is protected on laboratory specimens during transport so that patient privacy is maintained.	Transport bags are not equipped with locking devices to protect PII on laboratory specimens during transport from the Rancho Cucamonga CBOC to the parent facility.
	Adequate privacy is provided to patients in examination rooms.	
	Documents containing patient-identifiable information are not laying around, visible, or unsecured.	
	Window coverings provide privacy.	
	The CBOC has a designated examination room for women veterans.	
	Adequate privacy is provided to women veterans in the examination room.	
	The information technology network room/server closet is locked.	
	All computer screens are locked when not in use.	
	Staff use privacy screens on monitors to prevent unauthorized viewing in high-traffic areas.	
	EOC rounds are conducted semi-annually (at least twice in a 12-month period) and deficiencies are reported to and tracked by the EOC Committee until resolution.	
	The CBOC has an automated external defibrillator.	
	Safety inspections are performed on the CBOC medical equipment in accordance with Joint Commission standards.	
	The parent facility includes the CBOC in required education, training, planning, and participation leading up to the annual disaster exercise.	
	The parent facility's Emergency Management Committee evaluates CBOC emergency preparedness activities, participation in annual disaster exercise, and staff training/education relating to emergency preparedness requirements.	

**Recommendation**

1. We recommended that managers ensure that PII is protected by securing laboratory specimens during transport from the Rancho Cucamonga CBOC to the VA Loma Linda Healthcare System.

## AUD

The purpose of this review was to determine whether the facility's CBOCs and PCCs complied with selected alcohol use screening and treatment requirements.<sup>2</sup>

We reviewed relevant documents. We also reviewed 38 EHRs and validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

**Table 3. AUD**

NM	Areas Reviewed	Findings
	Alcohol use screenings are completed during new patient encounters, and at least annually.	
X	Diagnostic assessments are completed for patients with a positive alcohol screen.	Staff did not complete diagnostic assessments for 6 (16 percent) of 38 patients who had positive alcohol use screens.
X	Education and counseling about drinking levels and adverse consequences of heavy drinking are provided for patients with positive alcohol screens and drinking levels above NIAAA guidelines.	Staff did not provide education and counseling for 3 of 21 patients who had positive alcohol use screens.
X	Documentation reflects the offer of further treatment for patients diagnosed with alcohol dependence.	We did not find documentation of the offer of further treatment for three of six patients diagnosed with alcohol dependence.
	For patients with AUD who decline referral to specialty care, CBOC/PCC staff monitor them and their alcohol use condition.	
	Counseling, education, and brief treatments for AUD are provided within 2 weeks of positive screening.	
X	CBOC/PCC RN Care Managers have received MI training within 12 months of appointment to PACT.	We found that 10 of 25 RN Care Managers did not receive MI training within 12 months of appointment to PACT.
	CBOC/PCC RN Care Managers have received National Center for Health Promotion and Disease Prevention approved health coaching training (most likely TEACH for Success) within 12 months of appointment to PACT.	
	The facility complied with any additional elements required by VHA or local policy.	

## Recommendations

2. We recommend that CBOC/PCC staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

3. We recommended that that CBOC/PCC staff provide education and counseling for patients with positive alcohol screen and drinking alcohol above NIAAA limits.
4. We recommended that CBOC/PCC staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
5. We recommended that CBOC/PCC RN Care Managers receive motivational interviewing training within 12 months of appointment to PACT.

**MM**

The purpose of this review was to determine whether appropriate clinical oversight and education were provided to outpatients prescribed oral fluoroquinolone antibiotics.<sup>3</sup>

We reviewed relevant documents. We also reviewed 38 EHRs and validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

**Table 4. Fluoroquinolones**

<b>NM</b>	<b>Areas Reviewed</b>	<b>Findings</b>
X	Clinicians documented the medication reconciliation process that included the fluoroquinolone.	We did not find documentation that medication reconciliation included the newly prescribed fluoroquinolone in 26 of 28 patient EHRs.
	Written information on the patient's prescribed medications was provided at the end of the outpatient encounter.	
X	Medication counseling/education for the fluoroquinolone was documented in the patients' EHRs.	We did not find documentation of medication counseling that included the fluoroquinolone in 18 (47 percent) of 38 patients' EHRs.
	Clinicians documented the evaluation of each patient's level of understanding for the education provided.	
	The facility complied with local policy.	

**Recommendations**

6. We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.

7. We recommended that staff provide medication counseling/education that includes the fluoroquinolone.

## DWHP Proficiency

The purpose of this review was to determine whether the facility's CBOCs and PCCs complied with selected DWHP proficiency requirements.<sup>4</sup>

We reviewed the facility self-assessment, VHA and local policies, Primary Care Management Module data, and supporting documentation for DWHPs' proficiencies. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

**Table 5. DWHP Proficiency**

<b>NM</b>	<b>Areas Reviewed</b>	<b>Findings</b>
	CBOC and PCC DWHPs maintained proficiency requirements.	
	CBOC and PCC DWHPs were designated with the WH indicator in the Primary Care Management Module.	

## CBOC Profiles

This review evaluates the quality of care provided to veterans at all of the CBOCs under the parent facility's oversight.<sup>c</sup> The table below provides information relative to each of the CBOCs.

Location	State	Station #	Locality <sup>e</sup>	CBOC Size <sup>f</sup>	Uniques <sup>d</sup>				Encounters <sup>d</sup>			
					MH <sup>g</sup>	PC <sup>h</sup>	Other <sup>i</sup>	All	MH <sup>g</sup>	PC <sup>h</sup>	Other <sup>i</sup>	All
Palm Desert	CA	605GC	Urban	Large	875	7,930	1,847	8,310	4,513	12,676	3,404	20,593
Murrieta	CA	605GB	Rural	Large	1,466	7,088	705	7,536	5,948	14,282	1,490	21,720
Rancho Cucamonga	CA	605GE	Urban	Large	1,238	4,949	625	5,258	7,408	9,793	1,677	18,878
Victorville	CA	605GA	Urban	Mid-Size	1,337	4,332	296	4,803	9,838	11,063	860	21,761
Corona (Riverside County), CA	CA	605GD	Urban	Mid-Size	860	3,461	96	3,811	4,569	7,512	310	12,391

<sup>c</sup> Includes all CBOCs in operation before March 31, 2013.

<sup>d</sup> Unique patients and Total Encounters – Source: MedSAS outpatient files; completed outpatient appointments indicated by a valid stop code during the July 1, 2012, through June 30, 2013, timeframe at the specified CBOC.

<sup>e</sup> [http://vaww.pssg.med.va.gov/PSSG/DVDC/FY2013\\_Q1\\_VAST.xlsx](http://vaww.pssg.med.va.gov/PSSG/DVDC/FY2013_Q1_VAST.xlsx)

<sup>f</sup> Based on the number of unique patients seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, the size of the CBOC facility is categorized as very large (> 10,000), large (5,000-10,000), mid-size (1,500-5,000), or small (< 1,500).

<sup>g</sup> Mental Health includes stop codes in the 500 series, excluding 531 and 563, in the primary position.

<sup>h</sup> Primary Care includes the stop code list in the primary position: 323 – Primary Care; 322 – Women's Clinic; 348 – Primary Care Group; 350 – Geriatric Primary Care; 531 – MH Primary Care Team-Individual; 563 – Mental Health Primary care Team-Group; 170 – Home Based Primary Care (HBPC) Physician.

<sup>i</sup> All other non-Primary Care and non-MH stop codes in the primary position.

## CBOC Services Provided

In addition to primary care integrated with WH and MH care, the CBOCs provide various specialty care, ancillary, and tele-health services. The following table lists the services provided at each CBOC.<sup>j</sup>

CBOC	Specialty Care Services <sup>k</sup>	Ancillary Services <sup>l</sup>	Tele-Health Services <sup>m</sup>
Palm Desert	Palliative Care	Audiology MOVE! Program <sup>n</sup> Diabetic Retinal Screening	Tele Primary Care
Murrieta	---	MOVE! Program Diabetic Retinal Screening	Tele Primary Care
Rancho Cucamonga	---	MOVE! Program Diabetic Retinal Screening	Tele Primary Care
Victorville	---	MOVE! Program	Tele Primary Care
Corona (Riverside County), CA	---	MOVE! Program	---

<sup>j</sup> Source: MedSAS outpatient files; the denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count  $\geq 100$  encounters during the July 1, 2012, through June 30, 2013, timeframe at the specified CBOC.

<sup>k</sup> Specialty Care Services refer to non-Primary Care and non-Mental Health services provided by a physician.

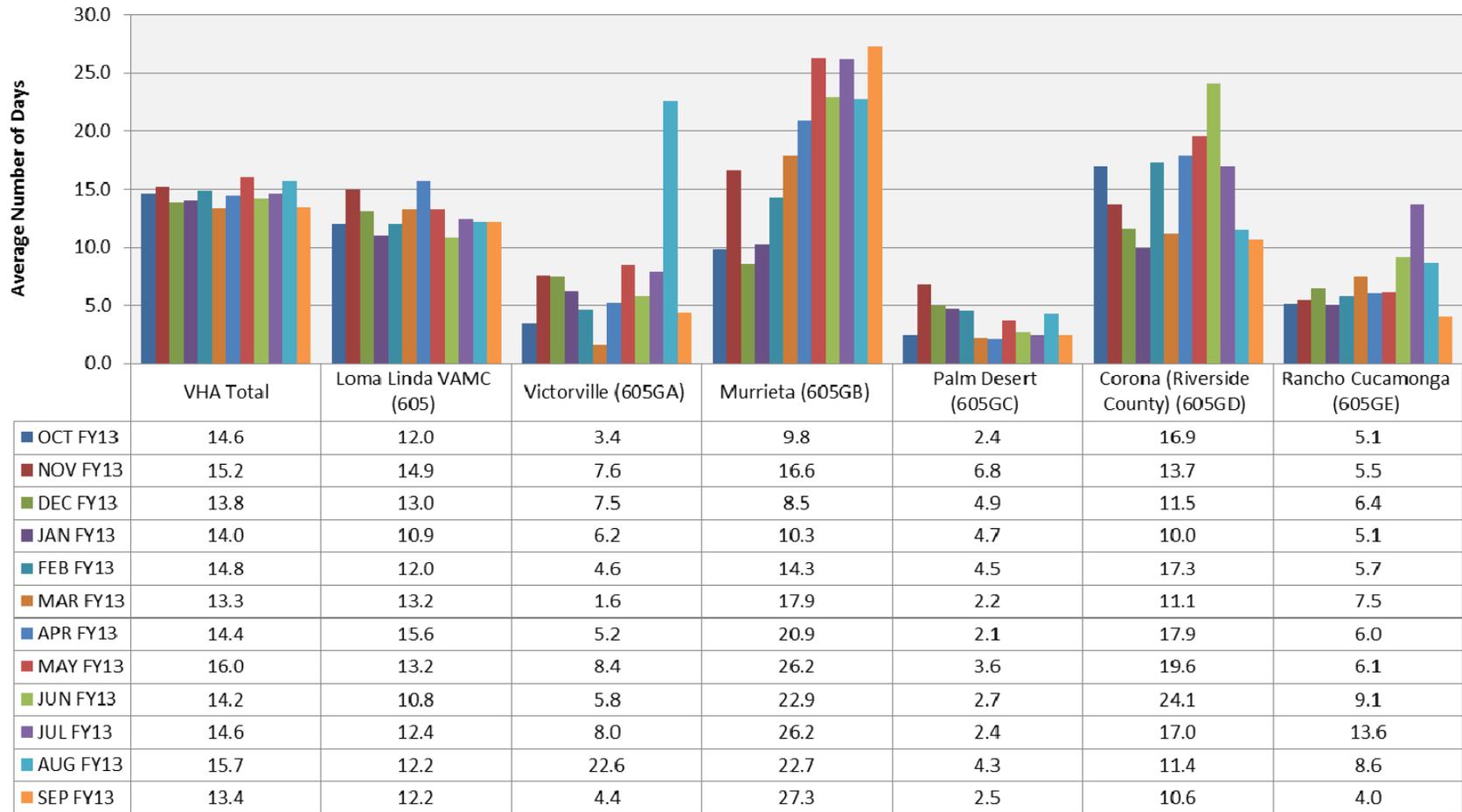
<sup>l</sup> Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.

<sup>m</sup> Tele-Health Services refer to services provided under the VA Telehealth program (<http://www.telehealth.va.gov/>)

<sup>n</sup> VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.

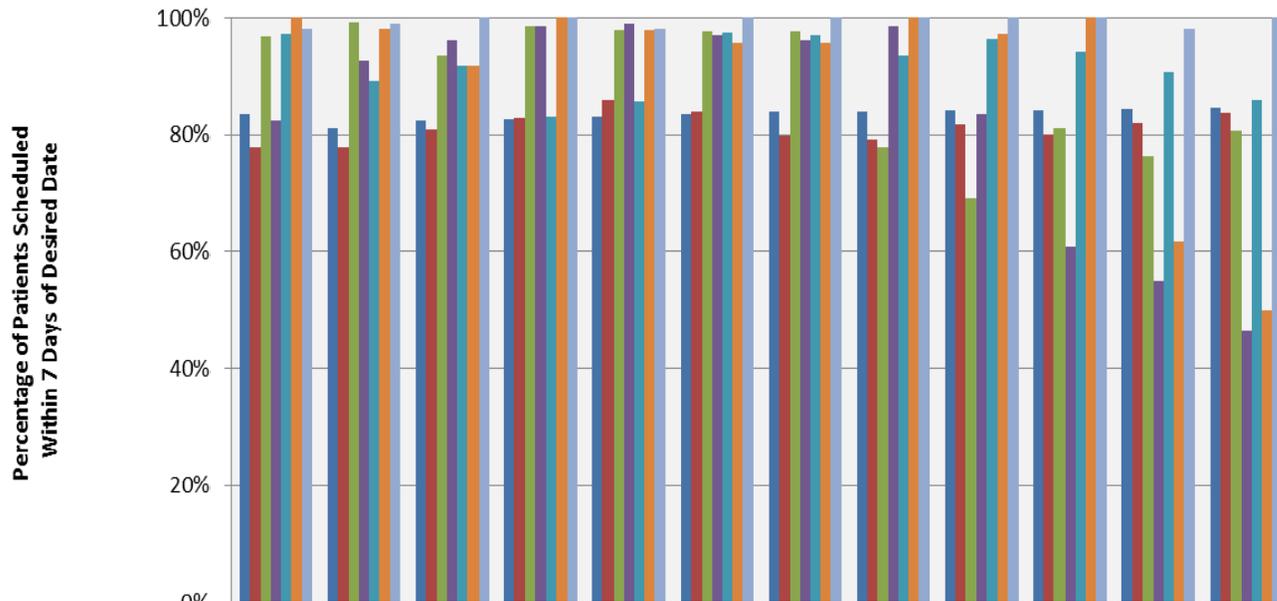
## PACT Compass Metrics

### FY 2013 Average 3rd Next Available in PC Clinics



**Data Definition.**<sup>5</sup> The average waiting time in days until the next third open appointment slot for completed primary care appointments in stop code 350. Completed appointments in stop code 350 for this metric include completed appointments where a 350 stop code is in the primary position on the appointment or one of the telephone stop codes is in the primary position, and 350 stop code is in the secondary position. The data is averaged from the national to the division level.

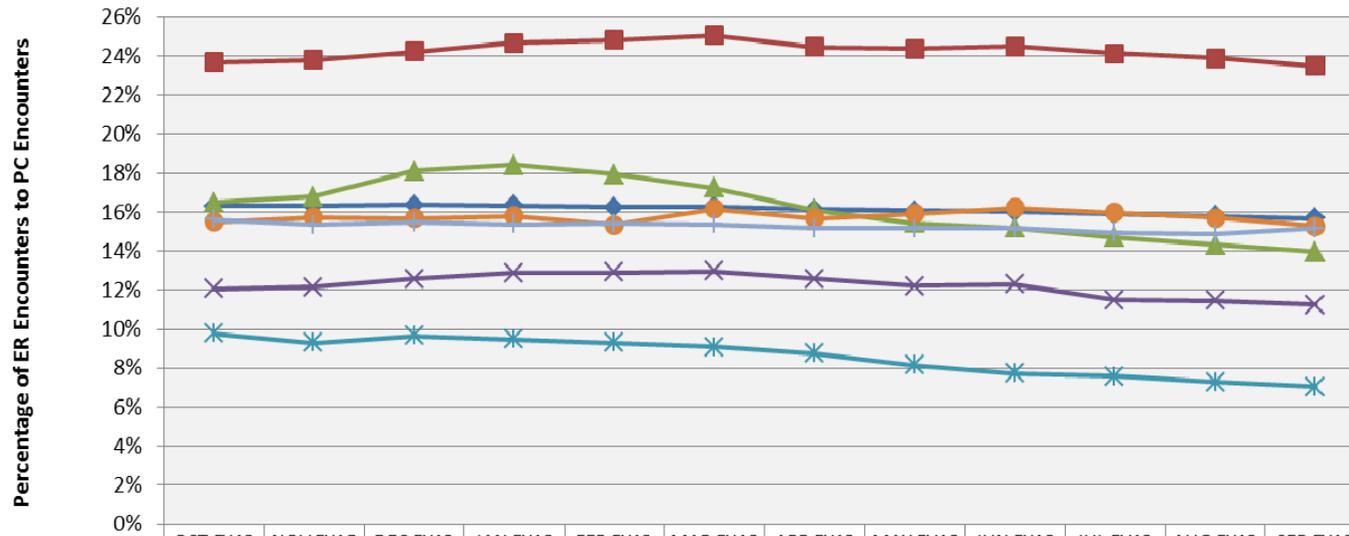
### FY 2013 Established PC Prospective Wait Times 7 Days



	OCT FY13	NOV FY13	DEC FY13	JAN FY13	FEB FY13	MAR FY13	APR FY13	MAY FY13	JUN FY13	JUL FY13	AUG FY13	SEP FY13
VHA Total	83.5%	81.1%	82.4%	82.6%	83.2%	83.6%	84.0%	84.0%	84.1%	84.3%	84.5%	84.7%
Loma Linda VAMC (605)	78.0%	77.7%	80.9%	82.9%	85.9%	83.9%	79.7%	79.2%	81.7%	80.1%	81.8%	83.7%
Victorville (605GA)	96.7%	99.2%	93.6%	98.6%	97.8%	97.6%	97.7%	77.9%	69.1%	81.1%	76.3%	80.7%
Murrieta (605GB)	82.4%	92.5%	96.2%	98.5%	99.0%	96.9%	96.2%	98.7%	83.5%	60.7%	55.0%	46.4%
Palm Desert (605GC)	97.1%	89.3%	91.8%	83.1%	85.7%	97.3%	97.0%	93.7%	96.4%	94.2%	90.7%	85.9%
Corona (Riverside County) (605GD)	100.0%	98.0%	91.7%	100.0%	97.8%	95.7%	95.7%	100.0%	97.2%	100.0%	61.5%	50.0%
Rancho Cucamonga (605GE)	98.0%	99.0%	100.0%	100.0%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%

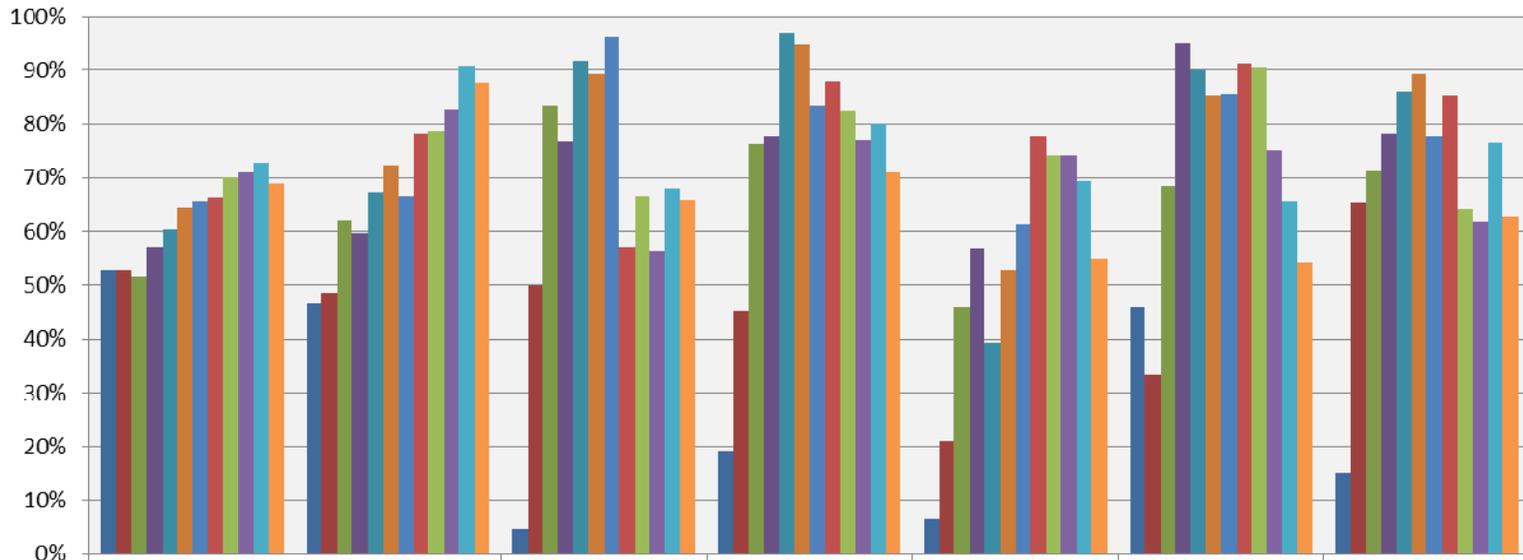
**Data Definition.**<sup>5</sup> The percent of patients scheduled within 7 days of the desired date. Data source is the Wait Times Prospective Wait Times measures. The total number of scheduled appointments for primary care-assigned patients in primary care clinics 322, 323 and 350. Data is collected twice a month on the 1st and the 15th. Data reported is for the data pulled on the 15th of the month. There is no FY to date score for this measure.

### FY 2013 Ratio of ER Encounters While on Panel to PC Encounters While on Panel (FEE ER Included)



**Data definition.**<sup>5</sup> This is a measure of where the patient receives his or her primary care and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care/FEE ER Encounters WOP (including FEE ER visits) *divided by* the number of primary care encounters WOP with the patient's assigned primary care (or associate) provider plus the total VHA ER/Urgent Care/FEE ER Encounters (including FEE ER visits) WOP plus the number of primary care encounters WOP with a provider other than the patient's PCP/AP.

### FY 2013 2-Day Contact Post Discharge Ratio



	VHA Total	Loma Linda VAMC (605)	Victorville (605GA)	Murrieta (605GB)	Palm Desert (605GC)	Corona (Riverside County) (605GD)	Rancho Cucamonga (605GE)
■ OCT FY13	52.8%	46.7%	4.7%	19.1%	6.7%	45.8%	15.2%
■ NOV FY13	52.9%	48.6%	50.0%	45.2%	21.1%	33.3%	65.4%
■ DEC FY13	51.5%	62.2%	83.3%	76.3%	45.9%	68.4%	71.4%
■ JAN FY13	57.2%	59.7%	76.9%	77.8%	56.7%	95.2%	78.3%
■ FEB FY13	60.4%	67.3%	91.7%	97.0%	39.4%	90.0%	86.1%
■ MAR FY13	64.4%	72.3%	89.4%	94.6%	52.9%	85.2%	89.3%
■ APR FY13	65.5%	66.7%	96.3%	83.3%	61.3%	85.7%	77.8%
■ MAY FY13	66.1%	78.1%	57.1%	87.8%	77.8%	91.3%	85.1%
■ JUN FY13	70.1%	78.7%	66.7%	82.5%	74.1%	90.6%	64.3%
■ JUL FY13	71.1%	82.7%	56.3%	77.1%	74.2%	75.0%	61.8%
■ AUG FY13	72.7%	90.8%	68.0%	80.0%	69.4%	65.5%	76.6%
■ SEP FY13	68.9%	87.6%	65.9%	71.1%	54.8%	54.2%	62.8%

**Data Definition.**<sup>5</sup> Total Discharges Included in 2-day Contact Post Discharge Ratio: The total VHA and FEE Inpatient Discharges for assigned primary care patients for the reporting timeframe. Discharges resulting in death and discharges where a patient is readmitted within 2 days of discharge are excluded from this metric.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 25, 2014

**From:** Director, Desert Pacific Healthcare Network (10N22)

**Subject:** **CBOC and PCC Review of the VA Loma Linda Healthcare System, Loma Linda, CA**

**To:** Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10AR MRS  
OIG CAP CBOC)

1. I concur with the findings and recommendations in the report of the CBOC and PCC Review of the VA Loma Linda Healthcare System, Loma Linda, CA.
2. If you have any questions regarding our responses and actions to the recommendations in the report, please contact me at (562) 826-5963.



Stan Johnson, MHA, FACHE

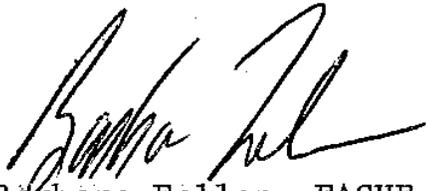
## Facility Director Comments

Department of  
Veterans Affairs

Memorandum

**Date:** March 24, 2014  
**From:** Director, VA Loma Linda Healthcare System (605/00)  
**Subject:** **CBOC and PCC Review of the VA Loma Linda Healthcare System, Loma Linda, CA**  
**To:** Desert Pacific Healthcare Network (10N22)

1. I concur with the Loma Linda VA Medical Center's response and action plans as detailed within this report.



Barbara Fallen, FACHE  
MEDICAL CENTER DIRECTOR

## Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

### **OIG Recommendations**

**Recommendation 1.** We recommended that managers ensure that PII is protected by securing laboratory specimens during transport from the Rancho Cucamonga CBOC to the parent facility.

**Concur**

**Target date for completion:** March 24, 2014

**Facility response:** The facility has completed the re-training of all VHA and contract couriers involved in the transport of laboratory specimens from the CBOC to the main laboratory. Padlocks are now used to close specimen containers. Padlocks will be attached by the staff of the submitting location (CBOC) before the courier takes possession of the container. The Lab Specimen Tracking List has been updated clarifying steps for securing personal identifying information during transport. Staff have been trained on new process for securing containers during transport.

**Recommendation 2.** We recommend that CBOC/PCC staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

**Concur**

**Target date for completion:** July 31, 2014

**Facility response:** The facility will educate the CBOC/Primary Care Clinic staff on VHA Audit C assessment requirements. Each day, a list of patients who have been determined to have had a positive Audit C screen, is uploaded onto a secured SharePoint site for CBOC/PCC Care Managers to obtain and follow up with an additional assessment as warranted. Compliance will be determined through ongoing EHR review that will be reported to Quality Council quarterly.

**Recommendation 3.** We recommended that CBOC/PCC staff provide education and counseling for patients with positive alcohol screen and drinking alcohol above NIAAA limits.

**Concur**

**Target date for completion:** July 31, 2014

**Facility response:** The facility will educate the CBOC/Primary Care Clinic staff on VHA Audit C education and counseling requirements and NIAAA drinking limits. Each day, a list of patients who have been determined to have had a positive Audit C screen, is uploaded onto a secured SharePoint site for CBOC/PCC Care Managers to obtain and follow up with an additional education and counseling. Compliance will be determined through ongoing EHR review that will be reported to Quality Council quarterly.

**Recommendation 4.** We recommended that CBOC/PCC staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

**Concur**

**Target date for completion:** July 31, 2014

**Facility response:** The facility will educate the CBOC/Primary Care Clinic staff on VHA Audit C documentation requirements for further treatment options that are to be offered to patients diagnosed with alcohol dependence. Each day, a list of patient who have been determined to have had a positive Audit C screen, is uploaded onto a secured SharePoint site for CBOC/PCC Care Managers to obtain and follow up with notifying the patient of the additional treatment options. Compliance will be determined through ongoing EHR review that will be reported to Quality Council quarterly.

**Recommendation 5.** We recommended that CBOC/PCC RN Care Managers receive motivational interviewing training within 12 months of appointment to PACT.

**Concur**

**Target date for completion:** July 31, 2014

**Facility response:** CBOC/PCC RN Care Managers will receive motivational interviewing (MI) training within 12 months of appointment to PACT by adding MI Training to the TMS Learning Plan and scheduling the training in the 2014 MI Training Calendar. Confirmation of attendance will occur at the time of the training, and those who are scheduled but are not in attendance will be notified of the date and time of the next MI training. Compliance will be audited every 6 months by completing a review of newly hired RN Care Managers by pulling a report from TMS.

**Recommendation 6.** We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.

**Concur**

**Target date for completion:** July 31, 2014

**Facility response:** The facility will re-train physicians on the medication reconciliation process. This will include a review of the medication reconciliation policy in addition to specific training related to fluoroquinolones and other antibiotics. Three training sessions will be held between now and June 15, 2014. The facility will conduct an EHR review of patients who have been newly prescribed fluoroquinolones to determine compliance with conducting medication reconciliation at the time of the patient's visit. The audit results will be reported to Quality Council on a quarterly basis.

**Recommendation 7.** We recommended that staff provide medication counseling/education that includes the fluoroquinolone.

**Concur**

**Target date for completion:** July 31, 2014

**Facility response:** The facility will re-train staff, physicians and pharmacists on the need to routinely perform and document medication counseling/education in EHR that specifically includes newly prescribed fluoroquinolones. The medication reconciliation template will include the education/training provided to the patient regarding fluoroquinolone use. The facility will conduct an EHR review to determine compliance with documentation of counseling/education. The audit results will be reported to Quality Council on a quarterly basis.

## OIG Contact and Staff Acknowledgments

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## Endnotes

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<sup>3</sup> References used for the Medication Management review included:

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<sup>4</sup> References used for the DWHP review included:

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<sup>5</sup> Reference used for PACT Compass data graphs:

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